Strategic Prevention Framework State Incentive Grant Questions and Answers from Informational Session on 11-1-04

Q1. Will the Power Point presentation be made available?
A1. It has been posted on the OSA website at www.maineosa.org.

Q2. How were the decisions about location of the three Regional Prevention Centers made?
A2. Several factors influenced this decision. First, we wanted to place them in the University system so that they aren't "owned" by any single state agency, including OSA. Second, we hope to increase the research capacity by placing them within the University system. Third, hopefully, we wanted to begin to create a mechanism for training of prevention specialists in the field. Fourth, we need to have some geographic coverage and placing them at USM, UMA, and UMO covers the three DHHS regions.

Q3. Can a strong coalition be considered as a regional prevention center?
A3. See question #2. Certainly prevention centers can be created at some local level such as for a county or other area. Discussion about terminology will be needed to clarify how terms are being used. For the purposes of this grant, three Regional Prevention Centers serving multiple counties will be funded.

Q.4 Why only three Regional Prevention Centers?
Q.4 There is only enough funding for three centers.

Q5. How do we find out the people at our local university to work with and when can we contact them?
A5. Linda Williams and Kim Johnson will be meeting with the Vice President of Research for the University of Maine system later this month. The next step would be to develop a Cooperative Agreement with the University system. Then staff will need to be hired. Please consult the website to find out more about how this process is unfolding.

Q6. Why are you developing a state strategic plan at the same time we are creating a state health plan, which should include this?
A6. One of the conditions of this grant is that a strategic plan be created. That plan must be approved by the Center for Substance Abuse Prevention before any evidence-based programming can begin. Linda Williams is attending a meeting about the State Health Plan and how this effort will coordinate with that initiative. A specific substance abuse prevention strategic plan will still need to be created and Muskie will be working with OSA and the SHY workgroup to develop that.

Q7. How many UGS and how were they selected?
A7. There are 8 coalitions that have been selected to participate in "case studies" with a researcher to help inform the field about the process used, the barriers encountered, and the lessons learned. A matrix of criteria was developed and nominations from state funders of coalitions were taken. To be included in the research study, a coalition had to

be nominated by at least 2 different funders. We also looked for a mix of different types of coalitions.

Q8. When will the case studies of existing coalitions (UGS) actually begin and what are the local responsibilities?
A8. We are in the process of hiring a researcher/evaluator to work with the coalitions. We hope that the work on this component will begin in January. The responsibilities are still being defined but include at least one meeting as a group to discuss questions to be added to case study (in addition to those developed by the researcher), documentation of the history of the coalition development, sharing of expertise with other coalitions, etc.

Q9. Why is Northern Maine excluded as a potential UGS partner?
A9. No northern Maine coalition met the criteria given in A7.

Q10. How do the UGS work with the seven bioterrorism regional centers?
A10. The UGS role in the beginning of this grant is to participate in the research project discussed in #8. It is not clear that they will have any defined role with the bioterrorism regional centers. If opportunities develop to work with the centers, that will definitely be explored.

Q11. Is the focus of the infrastructure work "youth" or adult prevention?
A11. In Year 3, the focus of this grant is on data driven decisions (based on the work of the epidemiologist) using evidence-based programming. Until the analysis is completed, we do not know which age groups, geographic areas, or unique sub-populations will be identified. The focus of the first 21 months is the development of local infrastructure and Regional Prevention Centers.

Q12. Will the data driven decisions be solely based on secondary data sets? What about primary data sets, i.e. surveys or qualitative, i.e. focus groups or key informants surveys?
A12. The State has a lot of survey data including the Maine Youth Drug and Alcohol Use Survey and a household survey that is currently being conducted. In addition, the Youth Risk Behavior Survey and the Behavior Risk Factor Surveillance System collect data relevant to this project. All those sources of data will be examined and other relevant data. At the local level, focus groups and key informants surveys should be part of a needs and resources assessment at the local level.

Q13. Once you apply for the grant, the epidemiologist makes final decisions about who is eligible. Is that correct?
A13. When the focus of the grant shifts to evidence-based programming in the areas of highest need, that will be determined by the epidemiological work.

Q14. When, where, how do we get the info "data" from the epidemiologist?
A14. The epidemiologist has yet to be hired although the process has begun. His/her first task will be to analyze the data at the state level. At this point in time, we do not know how much local analysis will occur.

Q15. Where is a good website or resource to learn more about evidence-based prevention practice?
A15. Two sites to check would be the SAMHSA website at www.samhsa.gov and the Northeast Center for the Application of Prevention Technology at www.northeastcapt.org.

Q16. Are you identifying the specific sub-populations or can you propose an assessment grant for a specific group?
A16. OSA has identified some specific sub-populations such as Native American, refugee/immigrant, deaf, GLBTQ (gay, lesbian, bisexual, transgendered, and questioning) but is open to assessment of other groups based on adequate definition and justification.

Q17. Would you expect statewide assessment of sub-populations or region specific, i.e. Somalis everywhere or Portland Somalis, Lewiston Somalis?
A17. We will post the answer to this question at a later date.

Q18. More people die of cancer, heart disease, and lung disease than of substance abuse. Why is so much on this single subject? And even though you say the risk factor prevention programs can/will be included, the programs "must" concentrate on underage drinking.
A18. One of the specific requirements of the CSAP grant is a focus on underage drinking. This is in response to the National Academy of Sciences report on underage drinking and its consequences. The CDC has recently classified alcohol as the third leading cause of preventable death in the United States, killing 75,000 people each year. The tragedy is that for those people it is estimated that there are 30 years of life lost. In other words, people who die from alcohol die in their teens, twenties, and thirties and not in their sixties and seventies. Alcohol is the number one drug of choice in the United State and in Maine. We don't need an epidemiological analysis to know that—thus it will be a focus of our efforts.

Q19. Is the focus of the project on all age groups or children and youth?
A19. That will be determined by the epidemiological analysis of existing data sources. It is suspected that youth and young adults (18-25) will rank high in area of need but so might the elderly, pregnant women, etc.

Q20. What will the RFPs that come out in February be asking for?
Two specific RFPs are expected to be issued in February 2005 from the SPF SIG funding—needs assessment grants for unique sub-populations and planning grants for coalitions to do additional work like development of a strategic plan, working with other coalitions on UGS process, etc.

Q21. What process is in place to clarify or refine the multiple meanings of prevention terms used in substance abuse, health promotion, public health, and the medical model?

A21. Many state agencies have jointly adopted a definition of prevention. More work needs to be done to standardize language or to provide help with the different terminology. This task could be a focus of the Strategies for Healthy Youth (SHY) workgroup.

Q22. How will you involve local communities in leadership of this project, including involvement in SHY, Children's Cabinet, etc. as well as developing the ultimate strategic plan and implementing it?
A22. The membership of the Children's Cabinet is in statute and would need to be changed through the legislative process to include community members. OSA in their first SIG invited local coalition coordinators to be part of their workgroups and plans to continue this practice, especially in the sub-committees developed by the SHY workgroup.

Q23. To what extent are youth and special populations going to be involved in creating/brainstorming and implementing prevention strategies?
A23. We included money in this grant for a Youth Summit and/or process to bring the many youth groups that exist together for a discussion of better coordination between the groups like YAP and Maine Youth Voices and for input. The Youth Legislative Advisory Council has a subcommittee on substance abuse—the members will play a significant role in this grant. Other mechanisms for meaningful youth involvement are still being explored.

Q24. How is the state epidemiologist going to collect data on risk and protective factors when all communities do not participate in the MYDAUS and we have little longitudinal data?
A24. There will be data at the county level where local data is not available.

Q25. Must the proposals financially benefit all or most of the partners in the coalition?
A25. It is not a given that coalitions will be the recipients of the evidence-based programming grants. For instance, there may be no coalitions able to work with the deaf community and a community based organization or statewide group would be the recipient of funding. The internal needs of the coalition are left to the negotiation of the members.

Q26. How are you eligible?
A26. If you are the strongest candidate to provide evidence-based programming to the groups, unique sub-populations, or geographic areas identified by the epidemiological analysis, then you will be selected through the state RFP process.

Q27. What are the qualifications for a coalition/organization to apply as far as a neutral player in the county? How will that be specified?
A27. See A26.

Q28. Can a community-based health agency apply for community assessment planning funds?
A28. Yes, particularly for the unique sub-populations needs assessment or they may apply to the Regional Prevention Centers to conduct a community needs and resources assessment in their area provided that a needs assessment has not already been done.

Q29. Are mentally ill children a unique sub-population?
A29. Yes.

Q30. Will the funding in years 3-5 for programming be for implementing new programs only or can this be used to fund the continuation of an existing program(s)?
A30. This money may fund the continuation of existing programs if the epidemiological analysis documents that the group being served is a high risk one and the program appropriately targets the existing risk and protective factors.

Q31. How small are the planning grants?
A31. Approximately $20,000 for 12 months.

Q32. If $1.9 million goes to communities—how many grants to you anticipate funding and roughly how much do you think that the community grants will be?
A31. The answer to these questions will be posted at a later time. The size of the awards may vary depending on the numbers of customers to be served and extenuating conditions—like a statewide agency that proposes to serve the GLBQT population that has to factor in distance.

Q33. What agencies will be able to serve the 18-25 year old population?
A33. The Higher Education Alcohol Prevention Partnership is already working with 17 of Maine's two and four year colleges and might apply to work with colleges. At this time, we don't know who is best positioned to work with young adults who are not in college although we believe the need may be found to be great.

Q34. Is there an attempt to assure that some funds are available to every town and city in the state?
A34. We would like to spread the infrastructure money as far as possible so that communities can at least conduct a needs and resources assessment that would allow them to apply for other funding. But realistically, there is not enough money in the programming phase to award funding to every town and city. Those awards will be based on need as demonstrated by the epidemiological analysis and capacity of the applicant organization/coalition to provide the services.

Q35. Can an UGS apply for another grant? Can an agency/coalition apply for two needs assessment grants for unique sub-populations? Can a coalition apply both for a needs assessment and planning grant?
A35. Yes—an organization and/or coalition may apply for different grants. OSA, however, is committed, to some geographic distribution of these funds.